



A participative approach to curriculum development for adults in addiction recovery across the European Union.

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Review

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1 POLICY AND PRACTICE IN THE PARTNER COUNTRIES

1.1 Introduction

The RECOVEU project brings together partners from the United Kingdom, Cyprus, Romania, Italy and Ireland with the aim of developing access to learning resources for people in recovery from addiction¹. This policy and practice review seeks to support project partners to develop a more nuanced understanding of the impact of drug policy and EU strategy in each of the partner countries, with a particular emphasis on how this influences practice in drug treatment. The aim was not to replicate the existing evidence base but use it as a foundation to develop a thematic approach to the overall project. With this in mind, RECOVEU partners have completed individual reviews of current drug policy and reflected on practice in their own country. In order to reflect on similar issues a structured questionnaire was developed which drew on the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Structured Questionnaire 28 on Social Reintegration and Reduction of Social Exclusion of Drug Users (EMCDDA, 2012). The review draws, therefore, on both existing data (for example, National Focal Point data²) and the experiential knowledge of the partners working in the field of addiction. This process has facilitated the development of a thematic framework to inform future work and, most importantly, gain a shared understanding of some of the contextual and structural issues affecting each partner. As we complete this review (October 2014) the EU Commission on Narcotic Drugs (EUCND) met in Vienna to discuss their input into the United Nations General Assembly special session. The consensus was to support an increased focus on the international drug control framework³. In the RECOVEU project the partner countries do not have forced labour in place of drug treatment or the death penalty but this is not the case around the world. As such, we are fortunate to be developing resources with people in recovery that aid their access to adult education and an opportunity to make positive changes in their lives.

1.2 Policy and Practice in the Partner Countries

What are the most prevalent issues relating to policy and practice nationally?

Across the five partner countries the main concerns relating to addiction policy and practice vary to some degree. In Italy the key issue is the low perception of risk associated with the use of cannabis, particularly among the younger population. Similarly, the use and abuse of alcohol among younger generations is viewed as problematic as this can serve as a 'gateway' substance. While the situation is somewhat different in Romania, in that the prevalence of illicit drug use is low compared to other EU Member States, there are indications that there is an upwards trend for the use of most drugs⁴. Although the majority of drug users are estimated to use heroin, the proportion of those who inject new psychoactive substances has increased and may constitute around a third of all problem drug

¹ Further details on the RECOVEU project can be found on the project website: <http://recoveu.org/>

² Unless otherwise stated data presented in the review is taken from National Focal Point data.

³ <http://www.eurad.net/en/Overview+of+United+Nations+Intersessional+Meeting%3A+23rd+October+2014.9UFRDWWC.ips>

⁴ <http://www.emcdda.europa.eu/publications/country-overviews/ro>

users (PDUs)⁵. As in Italy, the use of illicit drugs among young people is of particular concern in Romania; the general prevalence among 16 year olds in 2012 was 21.7% (European School Survey Project on Alcohol and other Drugs (ESPAD), 2012). Ireland also experiences these trends in poly drug use. Alcohol, cannabis, cocaine, benzodiazepines and 'Z' drugs use is significant with crack increasingly evident. The 'Z' drugs (or non-benzodiazepines, also called benzodiazepine-like drugs), are a class of psychoactive drugs whose pharmacological actions are similar to those of the benzodiazepines. The population in Ireland using heroin has plateaued and is now aging.

In 2010/11, there was an estimated 298,752 opiate and/or crack users in England. This corresponds to 0.87% of the population aged 15-64 (Health and Social Care Information Centre (HSCIC), 2013). However, around 2.7 million people aged 16-59 have taken an illicit drug in the last year, which equates to 8.2% of the adult population (National Treatment Agency (NTA), 2012a). In 2012, 197,110 adults were in contact with treatment services and 185,428 remained in treatment for 12 weeks or more - the time defining a treatment journey in the UK. There were 29,855 individuals recorded as leaving treatment free of drug dependency (NTA, 2012b). It is estimated that in excess of 10 million UK adults have an alcohol problem ranging from hazardous to harmful and ultimately dependent. A total of 109,683 adults received alcohol treatment in 2012 and 40,908 people successfully completed alcohol treatment (NTA, 2012b).

Whilst Italy experiences very similar levels to the UK and has a comparable population of 61 million, Romania has a prevalence of 0.18% within a much smaller population of 19.96 million. In 2012 in the Republic of Ireland, 8,923 people were on opioid substitution treatment which was introduced in 1992⁶. Cyprus is considered to be on the lower end of the scale of illicit drug usage with cannabis being the most prevalent drug used, followed by cocaine.

Which organisations and authorities are the main policy drivers?

Specific agencies with responsibility for developing the National Action Plan exist within each of the partner countries. However, these agencies sit within different government ministries. In Romania the National Anti-drug Agency (NAA) is a specialised legal entity under the coordination of the Ministry of Interior and Administrative Reform. The NAA oversees the development of a standard approach to reducing illicit drug trafficking and drug use and is responsible for the coordination of virtually all the services and professionals operating in the field. The Monitoring Centre for Drugs and Drug Addiction sits within the NAA. Therefore, although addiction is regarded as a medical condition within Romania, the NAA does not sit within a health-related ministry because the criminality aspect takes precedence in terms of policy-making. In Italy the Department for Anti-drug Policies (DPA) is a permanent structure of the Presidency of the Council of Ministers. The DPA is responsible for defining and monitoring the National Action Plan against drugs according to EU guidelines. Although not located within a health ministry, the DPA works in synergy with the health service which is responsible for Treatment and rehabilitation, operationalised through the Regional Health Service via local health services.

In Cyprus, Ireland and the UK the agencies responsible for overall drug strategies are linked more directly at a policy level to health-related government departments. The Cyprus Anti-Drugs Council

⁵Please note that although initially the term 'Service Users' was intended to be used to refer to people in recovery this did not always make sense within the context of the text. The term 'drug users' has been used instead.

⁶www.emcdda.europa.eu/data/treatment-overview/Ireland

(CAC), established in 2000, is responsible for the development and implementation of the National Drugs Strategy and the National Action Plan on Drugs aligned with the EU Drugs Strategy. It is regulated and financed by the Ministry of Health. CAC is solely responsible for the coordination of prevention and intervention programmes in the field and for the monitoring of governmental and non-governmental addiction services. CAC is also responsible for funding services, particularly those run by non-profit organisations.

In Ireland the main policy drivers emanate from the health sector which has a dedicated addiction service set apart from primary care. There is an Oversight Forum on Drugs chaired by the Minister of Health and with multi sector representation including voluntary and community representatives. The Department of Health is charged with the daily operation of drug policy through two units: the Drugs Policy Unit and the Drugs Programme Unit. A Drugs Advisory Group (DAG) advises the Minister on the implementation of the drugs strategy. The National Drug Rehabilitation Implementation Committee (NDRIC) oversees the implementation of the rehabilitation strategy.

The situation within the UK is somewhat complex which presents challenges when presenting and interpreting the data. The UK government is responsible for setting the overall drugs strategy and for its delivery in the devolved administrations only in matters where it has reserved power; policies concerning health, education, housing and social care are confined to England, while those for policing and the criminal justice system cover both England and Wales. A number of powers are devolved to Northern Ireland, Scotland and Wales, and each of these countries has its own strategy. Strategies in Northern Ireland and Wales address both illicit drugs and alcohol. In April 2013, Public Health England (PHE) was established and the National Treatment Agency (NTA), previously part of the National Health Service (NHS) which led on the implementation of the drug strategy, became part of this overarching national body, established to protect and improve the nation's health and wellbeing and to reduce inequalities (PHE, 2013). There are three themes in UK drug strategy: reducing demand, restricting supply and building recovery. The strategy is only concerned with illicit drugs; there is a separate strategy for alcohol misuse focused on 'binge drinking'. In the UK, binge drinking for men is drinking more than 8 units of alcohol and for women, more than 6 units of alcohol (NHS, 2012).

What is the dominant discourse around the national response to problem drug use?

Within each of the partner countries people with addiction related problems are referred to differently. This 'label' reflects the dominant discourse around addiction. In Italy they are referred to as 'drug abusers', for example. The dominant discourse around the response to problem drug use is that drug addiction is a preventable, treatable and curable disease. Therefore, all policies and strategies are set up to recognize that this condition is not just a social problem, but also a serious public health problem affecting not only the health of people dependent on drugs, but also third parties who may be damaged by what is regarded as risk-taking behaviour. Within this discourse, illicit drug use is not considered part of an individual's rights because the consequences of such behaviour may impinge on the rights of others. However, this issue is controversial and the debate remains heated.

In both Romania and Cyprus the dominant discourse includes notions of criminality. There is a clear definition of drug addiction that involves illegal drug use in Romania; reducing supply and demand is the most important part of the anti-drug strategy. As a result less priority is given to the treatment and recovery of drug users. The public perception of drug addiction is that it demonstrates a lack of willpower to control behaviour; alcohol/drug users are regarded as incurable 'sinners' and less

trustworthy. This moral view is wide-spread and encouraged by some churches and professionals who do not work within the Minnesota framework⁷. The voices of those faith-based organisations and professionals working in the private sector within the Minnesota framework are fewer and do not yet have the power to influence policy and procedures. However, main cities such as Cluj-Napoca, Lasi and Bucharest have a good network of non-governmental organisations (NGOs) providing services which are more focused on psycho-social rehabilitation and social reintegration using the disease model of addiction.

In Cyprus there is also a high level of societal taboo around drug addiction. An attempt to address this issue is being made through the promotion of social reintegration although this is currently only in its early stages. For example, CAC plans to socially reintegrate those with a history of drug addiction effectively by providing them with housing, education and employment and gender specific treatment services. Some treatment centres place more weight on social reintegration than others aiming to eliminate social stigma by effective reintegration. CAC has also sought to remove the 'criminality' dimension of drug addiction which had acted as a deterrent to PDUs accessing treatment services, e.g. by providing guidance to the media on appropriate terminology to use.

Within Ireland the discourse on how to deal with the problem of drug abuse remains dominated by the medical model which favours a management approach via methadone and brief interventions with little focus on improving the individual's quality of life. However, there is now an emerging recovery discourse in Ireland influenced by developments in America and the UK.

In England the dominant discourse is a combination of criminality and public health. As in Ireland, a focused Harm Reduction approach to protect public health began in the late 1980s and early 1990s in response to increased concerns about HIV transmission. Harm Reduction is a pragmatic approach which considers the availability of support to use drugs as safely as possible to be the key to supporting people. Perceptions of Harm Reduction approaches have become increasingly contentious and are being replaced by recovery focused strategies which more specifically promote abstinence. However, the Harm Reduction approach remains fundamental to services in addiction in that all treatment seeks to reduce harm and addresses other areas of risk such as hepatitis transmission. There is also support for the introduction of drug consumption rooms with the aim of reducing drug related deaths (BMJ, 2013). The provision of Naloxone, an opioid antagonist which reverses the effects of overdose, is currently available to people at risk and in some areas their family members. Since May 2012 the Advisory Council on the Misuse of Drugs has eased restrictions on the supply of Naloxone to support the drug strategy aim of reducing drug related deaths.

1.3 Definitions of Addiction, Treatment and Recovery

In all partner countries ascertaining clear definitions of Addiction, Treatment and Recovery is challenging.

Addiction

⁷ The Minnesota Model evolved from early treatment models concerned with abstinence and the disease framework. Further information can be found in Anderson, D.J., McGovern, J.P. and Dupont, R.L. (1999). The origins of the Minnesota model of addiction treatment—a first person account, *Journal of Addiction Disorders*, 18(1):107-14

There are definitions in the literature and anecdotal reports but for all partners the discussion is blurred by moral paradigms which impact on approaches, interventions and perceptions of what it is to be addicted, and what this says about an individual and their place in the community. In 2012 the UK Drug Policy Commission (UKDPC) referred to the UK drug policy debate as 'toxic', driven by a need to maintain the status quo and affected by lack of agreement about what actually constitutes the evidence base (UKDPC, 2012). All the partner countries appear to share similar characteristics around a dominant medical model. Additionally, partners all acknowledge the existence of psycho-social aspects of addiction albeit with differing levels of emphasis. However, what is clear from this review of policy and practice is a moral overtone which influences this debate, often to the detriment of the needs of individuals who are experiencing problems related to drugs of abuse including alcohol.

An example of the impact of this moral overtone is explored by the Romanian and Italian partners, who both describe the way in which the misuse of alcohol is treated as a separate issue. In these countries, as is common across Europe, alcohol consumption is widely acceptable but developing dependence is not. In Italy this dependence is treated as a different type of addiction due to alcohol's legal status. Responding to dependence, therefore, is influenced by the cultural norms in each country; while some are responsive others are less so. Some partner countries, such as the UK, generally approach alcohol and drug misuse in very similar ways; for example, data on problem drug use in the UK often relate to misuse of both drugs and alcohol.

In the UK addiction is predominately defined as either a chronic relapsing condition in the medical paradigm or as the compulsive habitual use of substances in the behavioural paradigm. There is a general consensus, however, that a combination of both biological and behavioural elements contributes to addictive behaviour. This complexity is recognised in all the partner countries. Addiction is generally categorised in one of three ways in the literature: a disease, a choice or a coping strategy. This can influence approaches to treatments in both strategic and individual responses (Russell et al., 2011). In Cyprus addiction is considered as a dependence disorder not only on illegal substances but also on harmful use of alcohol. The National Strategy accepts the nexus of individual, social and economic conditions that lead to addiction and the long journey to overcome it. It calls for a holistic approach to the treatment of addiction which includes all addictive substances, legal and illegal, and treating addiction as a priority health policy.

Ireland shares a dominant UK view that addiction is a chronic relapsing condition characterised primarily by a medicalised response. DSM⁸ 5 is used as the diagnostic tool to determine prevalence. However, there is a growing acceptance that a bio-psycho-social response is more appropriate. Drug use is illegal and heavily stigmatised, and paradoxically, there is a huge stigma for the drug addict but sympathy for the alcoholic.

In Romania addiction is viewed as a psychiatric disorder and predominately treated within medical institutions. The disease model of addiction (i.e. the need for total abstinence) was only introduced recently by NGOs providing psycho-social services which take the view that addiction is a complex bio-psycho-social-spiritual disease. There is more clarity in relation to the definition of addiction that involves illegal drug use. People are defined as dependent (addicts) when they are obviously in a state of physical dependency.

⁸ Diagnostic and Statistical Manual of Mental Disorders - the standard classification of mental disorders used by mental health professionals in the United States and often referred to internationally.

Although addiction has a shared definition in the legal and therapeutic contexts in Italy, there are difficulties in changing viewpoints. Many people take the view that a drug abuser is a criminal rather than someone who is ill. Addiction is characterized by a strong craving and search for a substance, low capacity to recognise individual problems, and a dysfunctional emotional response. The Italian government's stance is that some individuals can be characterised by a specific neuro-psycho-biological, social and environmental profile, and are more likely to develop an addiction. Within this model of addiction even occasional use is considered dangerous. As a result, strategy and practice are oriented towards early intervention to avoid a real addiction: not only through awareness-raising activities, but also in order to promote better lifestyles and empowerment of the individual.

Treatment

The term 'treatment' is used in the UK to describe a range of pharmacological and behavioural interventions. This includes information and advice, initial screening, needle and syringe programmes, psychosocial and pharmacological treatment, detoxification, and residential rehabilitation. Substitution treatment remains the main treatment in the UK for opiate users, and is mostly offered through specialist outpatient drug services, commonly in shared care arrangements with general practitioners. Oral methadone is the drug of choice for substitution treatment, but buprenorphine has also been available in the UK since 1999. In England, prescribed injectable methadone and diamorphine are also available, although this is rare.

The approach to treatment and intervention in the UK is a combination of public health and prohibition measures. Whilst prescribing, predominantly for heroin addiction, is dominant there are also Harm Reduction interventions and increasingly the recognition that mutual aid is a valuable source of support in recovery (National Institute for Clinical Excellence (NICE), 2012). The development of 'recovery champions' is supported by a vibrant recovery advocacy movement. The UK Recovery Walk (UKRW) is a Community Interest Company established to support people in recovery and offers visible examples of success. This organisation promotes the role of recovery champions as advocates for people entering recovery. This provides opportunities for 'social learning' when people encounter others in recovery, and also informs the wider community that people can and do recover from drug and alcohol dependence.

In England, a recent report (NTA, 2011) by an expert group on recovery-oriented treatment provides a new national framework for best practice for practitioners and effectively updates and replaces the Models of Care (2009 and 2012) document and the previous four-tiered treatment framework in England. The new guidelines emphasise personalised recovery interventions that work with individuals to achieve abstinence through increased levels of social reintegration. This assumes for many that a lack of personal and social capital is preventing individuals from being integrated into their communities but does not specifically address the needs of the drug and alcohol misusing population who remain in employment and who have a higher capacity for community engagement. In this respect it echoes other strategies focused on the most problematic individuals in terms of creating difficulties in communities, and with petty crime, public safety and public health issues being prominent concerns.

The overall aim of treatment in Italy is to increase the opportunity for addicts to have a more satisfying life, to be independent and responsible and to become drug free. Key to this is the restoration/development of a positive self-image and positive relationships. There is a distinction made between global and specific outcomes; the former relate to an individual's behaviour over time with a focus on longer term goals and increased social integration while specific outcomes are the short term goals of treatment and cessation of drug use. In Italy practitioners have started to

enact ideological change informed by the evidence base and are beginning to promote the idea that drug users should not be isolated and discriminated against. Furthermore, they have the right to receive free care which also extends to those in detention for criminal offences. The aim is to base all interventions upon gradual but continuous steps oriented towards recovery and healing. Treatment shall be accessible, equitable and personalised, aiming in the short term to stabilise the problem and, in the long term, at rehabilitation and restoration of a healthy and autonomous life.

The aim of treatment in Ireland is to enable people to access clinical services, and to reduce the harms associated with drug use to individuals, their families, the community and society. Settings consist of three types; clinics, Level 1 (up to 15 patients) and Level 2 (up to 35 patients) doctors. Treatment services also exist in prisons. The clinics are a mix of large style facilities with smaller satellite clinics set up in the 1990s to get as many people into services as quickly as possible. Treatment includes the provision of methadone together with the option of detoxification, stabilisation and rehabilitation. Counselling services are also provided. This is underpinned by assessment, care planning and the option of engaging in an integrated care pathway and outcome monitoring under the aegis of clinical governance. The aim is to normalise services by increasing general practitioner involvement, to address poly-drug use as a priority, including prescription and over the counter drugs and alcohol. The National Drug Rehabilitation Framework (Doyle and Ivanovic, 2010), the Draft Evaluation Report of the National Drug Rehabilitation Pilot (Barry and Ivers, 2013) and the HSE Northern Area Review (PIRC/UCL Partners, 2013) are all promoting reorientation towards a client centred, integrated and accountable service journey.

The dominant treatment methods in Cyprus are psychosocial interventions which are used by all counselling, outpatient and inpatient programmes. There are 23 treatment programmes in Cyprus, nine of which are government funded and inclusive of legally prescribed drug programmes, while 14 are private. The majority of treatment centres approach addictive behaviours, whether heroin use or gambling, through psychotherapy and medication. Counselling centres emphasise the importance of motivational development and support, whereas outpatient and inpatient rehabilitation programmes centre on individual and group counselling, therapy and psychotherapy. Among the programmes provided, only two (one inpatient and one outpatient) target drug users specifically. Similarly, there are only two centres (a government facility and a private clinic) that provide detoxification services. Finally three programmes offer substitution/maintenance services (one of which is a private clinic, and the other two are governmental programmes). Although there are ongoing additions to the treatment services there is a substantial lack of specialised treatment services for drugs other than heroin. Substitution treatment was introduced in Cyprus in 2007, with around 44% of eligible clients engaging with the service after its implementation (NFP data).

In Romania the national strategy focuses on reducing illegal drug use, Harm Reduction programmes and primary medical treatment services for drug users (i.e. services for the treatment of withdrawal). There are three levels of treatment in Romania:

1. Primary medical assistance units and emergency rooms, and generic social services via public, private and NGOs.
2. Integrated care services (referral centres operated exclusively by public treatment services) and psychiatric units for primary or specialised care and mental health treatment.
3. Inpatient detoxification treatment and residential therapeutic communities. (Methadone was introduced in 1998, buprenorphine in 2007 and the combination buprenorphine/naloxone in 2008.)

Alcohol dependency (if it is considered a dependency⁹) is viewed differently than drug dependency. While alcohol is culturally accepted and commonplace, dependency is associated with a high degree of stigma and shame, for both the 'alcoholic' and their family. The professional community agrees with and accepts the international definition that addiction is a disease, but at the practical level there is no knowledge about intervention and treatment, except for the medical treatment of withdrawal. Most of the services are detoxification focused and do not address the psycho-social needs of the individual with after care. The medical community also acknowledges the problem of alcohol abuse and dependency as defined in the DSM, but again there is no knowledge about intervention and treatment at a practical level, except for the medical treatment of withdrawal. The person is regarded as mentally ill and treatment is provided by psychiatric units where they undergo long-term medical treatment, mostly with benzodiazepines. Currently, there are no tools provided to professionals (e.g. family doctor) to evaluate alcohol use in order to facilitate early intervention for abusive drinkers.

Recovery

There is no clear consensus on the definition of addiction recovery in the UK; there is a tension between those who regard total abstinence from all substances and compulsive behaviours as recovery and those who suggest recovery is a self-defining state with the potential for medication or controlled use. However, in 2008 the UK Drug Policy Commission published a consensus statement on recovery:

The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.
(UKDPC, 2008, p6)

The 2012 report, 'Putting Full Recovery First'¹⁰, outlines the UK Government's roadmap for building a new treatment system based on recovery and guided by three overarching principles: wellbeing, citizenship and freedom from dependence. These overarching principles are indicative of an increasing understanding that recovery is a process and not necessarily one with the same fixed end point. However, the most dominant discourse is that recovery is total abstinence

In the UK, recovery is seen as a personalised process around well-being and quality of life; a lived experience rather than something diagnosed. Recovery tends to include increased levels of hope and aspiration, some measure of community engagement or citizenship and some measure of sobriety; it may also include abstinence, reduced use or medically supported recovery and may be subject to change over time (RSA, 2014). A similar definition exists in Ireland where recovery is defined as a return to a normal state of health and wellbeing through the development of personal and social assets that people need to initiate and sustain their recovery. In Ireland there is an emerging discourse which draws on Cloud and Granfield's (2009) conceptual model of recovery capital and the work of Strang (Recovery Orientated Drug Treatment Expert Group, 2012). Rehabilitation is seen as episodic whereas recovery is seen as lifelong. More recently, a review of the HSE Northern Area Addiction Services (HSE, 2013) recommended greater service user involvement with structures that

⁹ In some countries alcohol dependency is not universally recognised as an addiction. Instead it is perceived rather as weakness for alcohol.

¹⁰https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98010/recovery-roadmap.pdf

meet their needs and facilitate their goals. The principles underlying this are based on the perception that there are many pathways to recovery, that it is self-directing and empowering and involves personal transformation and change. Moreover, recovery is viewed as a continuum of improved health and wellness and that it is supported by peers and allies and involves (re)joining and (re)building a life in the community.

In Cyprus, as in Romania, there is a lack of consensus and exploration around recovery which represents a gap in the research base. According to CAC, recovery is an open-ended process within which the individual may relapse even after successful treatment. Treatment centres do not necessarily regard relapse as failure as it can serve as a remediable experience which can also help the centres to identify risk factors and continuously improve their services. In Italy the term rehabilitation is an outcome of therapeutic programmes which deal with the development of social skills in order to foster full social reintegration and may be viewed as recovery. The needs of specific groups, for example, women and poly-drug abusers, are also beginning to be addressed with an increased focus on the reduction in the age of first contact with drugs, and outreach with younger people as a preventative measure which also addresses alcohol use.

1.4 Policy and Strategic Response

At a national level each of the partner countries has developed a National Action Plan or Drug Strategy. Table 1 identifies the defining elements within each country's strategies.

Policy area	Cyprus	Ireland	Italy	Romania	UK
Prevention	x	x	x	x	x
Reduction of drug use and consequences on public health and order, and safety		x	x	x	
Care & prevention of related disease		x	x	x	
Building recovery through support provision					x
Rehabilitation & reintegration	x	x	x	x	
Treatment	x	x	x	x	
Observation / monitoring /evaluation of treatment results to inform policy response / research		x	x	x	
Reduction/regulation of supply / Reducing drug trafficking and smuggling	x	x	x	x	x
Facilitating cooperation between public institutions and the non-governmental sector		x	x	x	
International collaboration	x	x	x	x	

Table 1: Key policy areas identified in National Action Plans/National Drugs Strategies for the partner countries.

What is the overall aim of the policy?

The overall aim of the Italian National Action Plan (PAN) is to encourage an interdisciplinary treatment approach. The focus is on early outreach and using the diagnostic assessment process to place people on appropriate personalised and integrated treatment programmes. To facilitate this drug treatment units devoted solely to social reintegration have been established and the number of activities aimed at involving the social/interpersonal spheres of drug users and improving their education and professional skills is being increased. Steps have also been taken to assimilate reintegration activities into the work of local agencies (e.g. local health authorities and therapeutic communities). In addition, emphasis has been placed on directly involving public companies in

reintegration activities through the allocation of contracts to social cooperatives and on encouraging organisations to become self-financing through the development of corporate social responsibility programmes.

The National Strategy for Cyprus also aims to encourage and support multi-agency working focusing on social services, professionals, drug users, and the public and voluntary sectors acting together. However, the implementation of the strategy could be affected by the recent economic downturn which may result in the closure of some non-governmental treatment centres impacting on both the quality of the service provided and the effectiveness of the multi-agency approach.

In Romania a degree of tension is evident within the National Drugs Strategy in attempts to achieve a balance between actions to reduce supply and demand, and the provision of Harm Reduction services and social reintegration. The NAA is strongly focused on reducing trafficking and use of illicit drugs with prevention and services oriented mainly to people who are dependent on illegal drugs. Prominent campaigns for drug use prevention have been developed aimed at the teenage population in schools. However, there is less emphasis on psycho-social recovery and developing an integrated system of care. As in Italy and Cyprus the Romanian strategy (2013-2020) seeks to add value through supporting inter-institutional cooperation and the development of an integrated approach. This has not yet been achieved and is proving to be problematic in some areas. For example, while the need for a coordination centre for the integrated services has been accepted unanimously, opinion is divided on which institution should undertake such a complex role. Some feel that the NAA should act as the coordinator, while others feel that it should be the responsibility of the Ministry of Health. Professionals working in some of the different agencies involved also appear to disagree, some arguing that coordination should take the form of a stronger collaboration between social work and health care services, while others envision this task being carried out by an 'independent institution' (Copoeru et al., 2013).

The National Drug Strategy in the UK has two overarching aims: to reduce illicit and harmful drug use and to increase the number of people recovering from dependence. Within this the strategy has three common strands¹¹. The first of these, 'Reducing Demand', focuses on education and prevention to stop first use. This is aimed primarily at stopping young people with some focus on those involved in criminal justice, mental health services and recreational use. The second strand, 'Restricting Supply', aims to increase border policing and disrupt drug supply across the UK through policing and the newly formed National Crime Agency. The third strand, 'Building Recovery', focuses on the provision of support to help people to recover, which means being free from dependence on drugs and alcohol in the context of strategy. The strategic aim is for services to be more locally responsive with local areas providing integrated services which encompass all elements of an individual's recovery: affordable and stable housing, employment, and support to maintain a stable family life and a life free from crime.

The strategic objective of the Irish National Drugs Strategy (2009-2016) is to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research. The aims are to reduce the supply and availability of drugs for illicit use; to minimise problem drug use throughout society; to provide timely substance treatment and rehabilitation services; to ensure the availability of data on the nature and extent of drug use; and to put in place an effective implementation framework for

¹¹ The devolution of administrations around the UK as outlined in the 2013 Drug Strategy annual review (Drug Strategy Team, 2013) means that different approaches to substance misuse may exist within Wales, England, Scotland and Northern Ireland.

the strategy. Alcohol has been included in the strategy as it is associated with both poly-drug abuse and homelessness and because of the harm it causes to the individual, family and society. The strategy identifies a need for more detoxification, residential and aftercare services, using a continuum of care model.

How is policy enacted in practice?

An emphasis on the local response is evident in Italy's strategy which is enacted through Regional Action Plans (PAR). Regional administrations are autonomous and determine their particular policies and strategies, and also their services' organisation, according to their specific needs. However, so far only three out of twenty regions have enacted a PAR because each region operationalises the National Action Plan at a different level. Overall, therefore, national strategy is fragmented and patchy with pockets of excellence and mediocrity. Drug treatment and rehabilitation is carried out by the Regional Health Service via Drug Treatment Units (SerT) based around multi-agency teams, Public Addition Services and the Addiction Department. Accredited services are also provided by private social institutions, volunteer associations, social cooperatives and therapeutic communities. The fragmented nature of the national strategy is exacerbated by the tendency of the disparate delivery services to have different types of interventions. In addition, many therapeutic communities and private organisations have specific recovery programmes based on their own vision and which are time limited. As a result, a new delivery framework is required as the diversity inherent within the regional systems has weakened the implementation and impact of action. Some agencies may also be reluctant to work with PDUs which is a barrier to multi-agency working. For example, while an association between psychiatric pathologies and addiction would require an integrated approach involving the cooperation of the Psychiatric Services, they do not wish to acquire PDUs as service users.

Throughout Romania the NAA has 47 local branches (Drug Evaluation and Counselling Centres) which are tasked with developing local strategy. Each centre houses a multi-disciplinary team made up of a physician, psychologist, social worker and a police officer. The coordinators at all levels are police officers and it is under their authority that activities related to the prevention of drug use and counselling take place. However, although all the Drug Evaluation and Counselling Centres are functioning they have not as yet implemented any treatment centres for rehabilitation; the four treatment centres that do exist are all private NGOs affiliated to the Church. In 2014 the National Department for Health Insurance issued a new 'basic medical package' which contains elements of prevention for chronic diseases (eHTA – cardiovascular risk). This raises the possibility of screening for alcohol and other drugs. However, Emergency Room and family doctors do not have any standardised tools and training to provide screening and brief counselling, and there are not yet any clear procedures for how the prevention will be put into practice. At this point they are also not talking about addiction treatment/counselling being integrated in the basic package of medical services.

CAC is responsible for the overall coordination and implementation of the strategy in Cyprus. One specific area that CAC is focusing on is interventions developed specifically for women as no such programmes were in existence previously; Agia Skepi, one of the main treatment centres, has been sponsored to develop a programme for this purpose. CAC is also working to establish better access to treatment centres through extending working hours and raising awareness via a website for service users and their families. The implementation of the plan is currently being evaluated by CAC which reports that all Ministries have not actively engaged with the plan. For example, one aim was to establish substitution treatment centres all around Cyprus. Although this has worked successfully in most cities, it has failed to expand in two cities because the Ministry of Health has not provided the necessary education and training needed to set up these centres. So although CAC is promoting

a wider development of these substitution treatment programmes, effectiveness largely depends on the Ministry of Health.

The Irish Health Service Executive (HSE) uses Service Level Agreements to mandate and monitor service activity and the National Drug Rehabilitation Implementation Committee (NDRIC) provides a framework through which services work. Fourteen local and ten regional drug task forces are involved in implementing the drug strategy on the ground. Key stakeholders are the statutory, voluntary and community sectors. As discussed previously, the main policy drivers emanate from the health sector which has dedicated addiction services set apart from primary care.

Each city in England has a Safer Cities Partnership, a drug strategy partnership or a similar body which articulates a plan for drug services in their area to meet the needs of the drug users, both those in treatment and those yet to enter treatment. Commissioners are encouraged to support services which provide the best fit to the aims of the UK strategy, to support people into abstinence and reintegration into employment and stable housing. Service providers tender for the services in a competitive bidding process focused on partnership and integrated working (NTA, 2010b). Although the UK Clinical Guidelines (Department of Health and the devolved administrations, 2007) provide evidence-based guidance on the treatment of drug misuse, rigid protocols on how drug treatment should be provided are not given. Instead guidance is provided on what represents a balanced range of recovery focused services in each area.

Until 2010 services were organised into four tiers (NTA, 2006) ranging from education and prevention to residential and forensic services. The Health and Social Care (HASC) review in 2012 focused on recovery oriented services and the formation of Health and Wellbeing Boards which will develop a holistic and integrated approach in each area (NTA, 2012b). In practice this means that each city currently has a different range of services and that providers can change every few years. There is no one clear approach and whilst this can provide locally responsive services, it can also drive a lack of consistency in provision, instability in the workforce and challenges for service users in what can be a protracted and open ended process of recovery. The financial constraints of the current economy also lead to difficulties in providing flexible, responsive services and well trained and supported teams to deliver interventions.

The UK Government is piloting a Payment by Results (PbR) system. This represents a new way of commissioning treatment services that involves paying treatment providers for providing three types of results:

- services users become free from dependence on drugs and/or alcohol
- reduced re-offending or continued non-offending
- improved health and wellbeing

The piloting of PbR in some areas is challenging as part payments are made to services which must have sufficient funding to provide staff and infrastructure. There is an energetic focus on supporting people to access mutual aid.

1.5 Approaches to Social Reintegration

How is social reintegration defined nationally?

Within the UK the role of Mutual Aid in developing social reintegration is being given increasing prominence both in the literature and policy enactment. Mutual Aid refers to social, emotional and informational support provided by group members in differing stages of recovery, e.g. 12 Step

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groups such as Alcoholics Anonymous and Narcotics Anonymous. There is also emerging evidence around Self-Management and Addiction Recovery Training (SMART) recovery groups which offer Cognitive Behavioural Therapy and therapeutic life skills advice to members.

Theoretical concepts around recovery capital are becoming part of the dominant discourse in the UK and are key to understanding the UK approach to social reintegration. Cloud and Granfield (2009) recently revisited their initial concept of Recovery Capital arguing that this has four components: social, physical, human and cultural. There is also evidence in the literature that interventions aimed at developing Recovery Capital may not come solely from drug services but from the wider social network. For example, Laub and Sampson (2005), reporting on the predictors of long-term desistance from crime, found that it is not direct treatment effects that trigger the growth of Recovery Capital but that it is more likely to be a range of life events and personal and interpersonal transitions, e.g. stable employment, ageing, interpersonal, life and coping skills, identity transformation, and attachment to a conventional person (spouse).

Ireland does not have an official definition for social reintegration. Following the recent financial crisis, there has been a significant reduction in social reintegration spending, resources and emphasis; those sections of the population who are most marginalised have been most affected by these cuts. There is poor emphasis on social reintegration within the current Harm Reduction framework and this is also evident at a practitioner level due to the medical hegemony which has directed this policy. Against the backdrop of the financial crisis, there is a lack of public or social housing which has left both the public and the homeless reliant on the market. There is also a shortage of affordable accommodation, particularly for those who are currently homeless and/or on benefit. Many of these are drug users struggling to get into recovery and having a roof over their heads is a first step in this process. While provision of detoxification and rehabilitation programmes may aid social integration, they are not consciously designed to fulfil this aim; organisationally and culturally they have been stand-alone.

Within Italy reintegration is strongly oriented to social and employment autonomy. Key to this definition are rehabilitation programmes for employment that support individuals to develop the skills and abilities needed to enable them to successfully gain work. Approximately a third of SerT clients were unemployed in 2011, with women having the highest rate of unemployment (Dipartimento Politiche Antidroga, 2011). In the same year three-quarters of the regions reported having established targeted strategies for social and work reintegration. Half had also developed housing programmes, e.g. temporary housing or reception centres and long-term housing. However, a recent study (Relazione Annuale al Parlamento, 2013) looking at best practice in the regions found that the extent to which they had complied with goals relating to social rehabilitation and reintegration was much lower compared to the other goals. Funding has also dropped sharply for these programmes. Similarly, few programmes aimed at workplace reintegration had been initiated despite this being identified as a high priority goal. Society also expresses a high level of mistrust and scepticism towards drug users which obstructs employment and social reintegration.

In 2010 Cyprus implemented the Employment and Social Integration of Vulnerable Population Groups programme which offers employers 65% of the salary costs for the first year of employment of members of vulnerable groups. The Plan for Financial Assistance for the Rehabilitation of Former Substance-Dependent Persons (developed by the Ministry of Labour) covers fees for vocational training or educational programmes as well as for attending higher education institutions. Emergency housing is also made available to meet the needs of drug users in treatment. The majority of addiction treatment services position social reintegration as one of their main objectives. However, although they provide information regarding the proceedings of social reintegration

activities such as what phase in which they are carried out, and how long after treatment clients are followed-up, there is less information regarding the content of activities.

Within Romania the term social reintegration is used in relation to people with a disability and offenders. For all other vulnerable groups the term used is social inclusion. This term refers to a multidimensional set of actions and measures in the fields of social protection, employment, shelter, education, health, communication, mobility, security, justice and culture, the purpose of which is to reduce social exclusion and promote active participation in all aspects of society. The most vulnerable groups are considered to be the Roma population, persons with disabilities, poor people, orphans, and children raised in orphanages. Drug users are not considered to be a vulnerable group in their own right, and are therefore only classed as vulnerable if they fall into such a group. Little data exists on the success of attempts to support the social reintegration of drug users and alcohol dependent persons. According to a recent study (NAA, 2013) drug users in Bucharest who were not included in specific assistance services provided by the public or private system, were mainly unemployed or remained at home. Few drug users (6%) considered themselves to be socially excluded because of a lack of education or training.

1.6 Current Opportunities for Adults in Recovery to Engage with Employability Programmes

In 2010, Job Centre Plus and the NTA in the UK jointly published a protocol to promote more effective approaches for people in drug treatment. This centred on information sharing but also promoted the use of local 'Recovery Champions' to train and raise awareness in staff. More recently this approach has been replaced by the 'Work Programme', a payment by results scheme targeted at those most likely to be long term unemployed (NTA, 2012b). There are programmes within the criminal justice system which may include work around addiction recovery but which are not specific addiction recovery programmes. In 2013 the Government's Strategy for Transforming Rehabilitation recognised that key social issues related to re-offending were low qualifications and lack of employment. An additional outcome has been the UK focus on employment for those in recovery. As a result some areas of the UK developed social enterprises as a way to overcome barriers to employment for ex-offenders. A recent report (Clinks and Social Firms UK, 2014) has looked at ex-offenders who had established social enterprises, considering how their learning could inform and assist others in creating their own employment. The report identifies several barriers including a lack of formal qualifications, literacy and numeracy difficulties, and a lack of work history.

The situation is similar in other partner countries. In Ireland there are soft skills programmes for drug users called Special Community Employment Schemes (CE) which are often sponsored by community organisations. There are 47 such schemes, 35 of which are located in Dublin. Individuals are allocated three years in total on the scheme and access is restricted to those who are unemployed, over 18 and in receipt of welfare allowances, and who have undergone assessment for suitability. However, uptake has fallen short of the places available (Lawless, 2006) and progression data is not collected. These programmes have also been heavily criticised on a number of grounds including a lack of inter-agency coordination, territorialism, lack of transparency and accountability, poor facilities and programmes, level of staffing and qualifications, and unease at progression routes (see for example, Bruce, 2004; Lawless, 2006; Keane, 2007; Van Hout, 2011). More recently in 2013, the allowance provided for women was cut from €208 per week to €20 and the number in Special CE fell substantially.

A Drug Courts programme also exists in Dublin for drug users facing criminal charges, who may opt for this instead of the mainstream criminal justice system. The Drug Courts may impose conditions on recovering addicts to follow a plan which includes a commitment to undertake work or courses. There are also Local Employment Centres (LECs), based in disadvantaged areas, which have career expertise on site for clients, many of whom come from a drugs background. The LEC can refer people to schemes or placements and there are options from volunteer networks to internships to get people involved in the labour market. Many of these centres secure discretionary funds which can be used to assist individual progression. Again there is a lack of data on this work in relation to recovering drug users.

A lack of specific data is also evident in relation to Romania where NGOs and the Public Social Work department provided EU funded programmes during 2010-13 for vulnerable adult clients to access vocational training in order to obtain a job in the community. Through collaboration with local drug treatment programmes, clients in recovery from drug addiction were included in these training and employability programmes, but there are no data on whether reintegration was successful.

In Italy, the level of availability of employment services designed exclusively for current and former drug users has, on average, received a positive evaluation (Relazione Annuale al Parlamento, 2013). Employment and job training programmes which were open to other groups were given particularly positive assessments. Drug users are included in the category of 'disadvantaged persons' and are eligible for programmes targeted at such groups even if they are not specifically identified as disadvantaged. Under Italian law opportunities for professional training to support social reintegration are available, albeit time limited. However, because the regions have autonomy in how this law is operationalised it is not universally available throughout the country.

In Cyprus, there are no exclusive programmes designed for current and former drug users; there are only general adult learning programmes within which vulnerable groups such as ex and current drug users are offered priority. The adult learning programmes, when informed of these groups use a more sensitive approach which aims to take into account the vulnerability of the individuals.

1.7 Current Opportunities for Adults in Recovery to Engage with Informal and Formal Learning

Formal learning

In the UK there are numerous formal qualifications on offer for people who wish to work in the drugs field. Some providers also offer higher education which is particularly supportive of people in recovery. An example is Action on Addiction which provides training in Addiction Counselling at the Centre for Addiction Treatment Studies (CATS). CATS run undergraduate degrees in Addiction Counselling in partnership with the University of Bath. CATS is part of Action on Addiction which provides residential and community addiction treatment and is quite unique as a provider of higher education. A self-reported 60% of students at CATS are in recovery from addiction with a significant proportion of the remainder reporting family members or friends who have addiction related difficulties. However, the offer at CATS relates to those people in recovery who wish to become drug workers or addiction counsellors and many people in recovery could benefit from a more diverse range of courses, in order that they can enter a career of their choice. Participants in treatment and in receipt of welfare benefits may be entitled to attend Basic Skills courses in Literacy, Numeracy and Information Technology but generally would be expected to attend 'job clubs' in order to gain employment related skills, create curricula vitae and complete application forms. Individuals in employment are rarely able to access funded courses. Despite general access to formal learning

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people in recovery also face challenges in gaining employment as many employers are reluctant to employ people with addiction histories, most specifically those with a criminal record. In the UK Ban the Box¹² is an organisation that is working to change the perception of people with criminal convictions, asking employers to give people a chance to explain their criminal convictions rather than be dismissed because of a tick box. The correlation between drug and alcohol dependency and crime means that this campaign should hopefully help people facing a wide-range of other barriers to work, including previous drug and alcohol misuse (BITC, 2014).

Opportunities for formal learning for recovering drug users in Ireland is primarily via the Special CE scheme which, while ostensibly a labour market intervention, runs a lot of educational outputs and constitutes the vast majority of projects offering adult education. Soilse, one of the partners in the RECOVEU project, is a drug rehabilitation programme which is unique in that it is under the auspices of the statutory health authorities and is separate to Special CE. Soilse uses an adult learning approach to build the person's capital and address their addiction. It also offers career guidance, literacy and educational support services in preparation for a transition to college. Specific support is available from a Recovery Coach on the Community course run by Finglas Addiction Support Service (FAST) in association with Dublin City University (DCU), now in its third year, for those in drug free recovery. There are also options to take part in introductory counselling and drug awareness courses which attract recovering drug users. The newly created Education and Training Boards offer some formal learning courses. Limited bursaries are also available from local drug task forces for study and funding for courses is often accumulated through donations from charitable institutions.

In Romania, Babes-Bolyai University's Social Work and Psychology Faculties have both developed curricula on addiction which are available for anyone with a high school degree, including people in recovery. The orthodox theological seminaries will integrate such curricula into their regular courses. The St Dimitrie Program is in the process of developing an academic training course for teaching staff, which, when introduced will play an important role in developing understanding of the disease model of addiction, and changing the views of professionals. This in turn can impact on public perceptions in Romania. In Cyprus formal learning opportunities for people in recovery include fully-funded university scholarships provided by CAC to people in recovery and current drug users, and sponsorship for secondary education.

In Italy 70% of drug users treated in public services are reported as having a low level of education with only 1.5% having a university degree. In 2011 reintegration was awarded a high priority for the Regions and the Autonomous Provinces. Despite this, employment and job training programmes created exclusively for current and former drug users were put into effect in only 35% of these areas. In Italy, the Permanent Territorial Centres – Adult Education (CTP-EDA) are responsible for adult learning including literacy for those adults who were unable to complete their high school career or who need to develop their skills for employment, social or personal reasons. Generally opportunities are related to formal learning. In 2011, half of the Regions and Autonomous Provinces created educational programmes/services targeting more than one type of socially disadvantaged group and programmes aiming to help individuals complete their basic education which were intended exclusively for current and former drug users.

¹² <http://www.bitc.org.uk/programmes/ban-box>

Informal learning

Informal learning opportunities are available in most treatment settings in the UK. They include: Relapse Prevention groups, general interest groups often focused on sporting activities and some providers offering Arts and Craft related activities in a therapeutic context. The UKRW charity has also published a Recovery Coaching Training Manual in conjunction with the McShin foundation which supports people in recovery becoming involved in coaching people in earlier stages of their recovery journey (UKRW, 2014). In Ireland learning can occur informally in fellowships or at a more formal level through the '12 Steps'. It also takes place in support groups or information sessions like Hep Cats for hepatitis/Aware for mental health/MABS for money advice and budgeting, etc. Access to self-directed learning is available through 'e' applications for subjects like personal development, Safe Pass, risk assessment, etc.

Informal learning is not widely available in Italy or Romania. There are informal learning opportunities available in Cyprus offered as part of the therapeutic programmes, e.g. a series of psycho-educational programmes and enhanced social reintegration programmes that serve to provide informal learning opportunities for both PDUs and people in recovery.

1.8 Current Opportunities for Adults in Recovery to Engage in Access to Learning Programmes

There are no specific opportunities for people in recovery to engage in Access to Learning programmes in any of the partner countries. Although some adults may access courses under the widening participation agenda there are no data available to measure this particular group's participation. While people in recovery may face some of the same issues facing students in widening participation groups, they may have specific needs or face additional barriers if they wish to engage in learning. Currently there are no Access to Learning programmes designed specifically for people in recovery or which take into account any specific issues or barriers they face.

1.9 Conclusion

The aim of this review has been to identify cultural similarities and differences between the partner countries not just in terms of policy espousal but also in enactment. This links to the specific aim of the review, i.e. informing the development of an 'Access to Learning' course pack for adults in addiction recovery. It is evident from this review that all the partner countries are guided by EU policies and strategy on drugs and addiction. However, there are clear differences in what has been implemented and the focus for this within the individual partner countries. An example of this is the situation in Romania where the dominant discourse includes notions of criminality and the definition of drug addiction involves illegal drug use. This viewpoint is expressed in policy which prioritises the reduction of the supply of and demand for illegal drugs.

In conducting the review we have sought not only to collate generic information about policy and practice but also to share interpretations of the practical challenges that may affect users of drug and alcohol services and subsequently people in recovery. One of the challenges identified in the review is working within a medical definition of recovery and a resultant lack of recognition of the way in which non-medicalised and non-addiction specific interventions can contribute to treatment and to the development of social capital and social reintegration. This situation differs for all the partners who are each at different stages in the extent to which the recovery discourse is recognised

at a policy level. This will clearly have implications for the utilisation of the resources developed as outcomes of the RECOVEU project.

It has also become evident that, regardless of demographic differences and rates of both incidence and prevalence of drug and alcohol misuse, all the partner countries are affected by the lack of consensus on addiction treatment and recovery. This takes place within the context of different moral paradigms that deeply affect how policy, and hence strategy, is enacted and, as such, link to the questions the RECOVEU project will explore. Public Health morality, for example, aims to promote good health and provide benefit to the general public through the restriction of harmful practices. Commercial Morality relates to the financial impact of both licit and illicit drug use illustrated, for example, in the UK where there is currently a call to add a 'treatment tax' onto the price of alcohol (Centre for Social Justice, 2014).

The evidence from this review suggests that drug users can often be the target of moralistic judgments within predominantly medical treatment contexts. Moreover, we would argue that these judgments can affect the way in which policy is enacted, the direction of funding and the availability of services in all partner countries. We would also argue that a continued focus on what addiction recovery means is necessary. It is only through reaching this consensus that service providers can move forward with providing the wide range of interventions needed to support sustained recovery from the difficulties caused by addiction and which will include both medical and psycho-social support. It is our conclusion that access to higher education can provide opportunities for people to both re-evaluate and re-establish their lives after addiction. It is against this backdrop that RECOVEU access to learning resources that enable people to develop and work towards their own learning goals in recovery will be developed.



2 Annex

2.1 Annexe 1

Education systems in the partner countries

Italy's education system is based on non-compulsory kindergarten (3-6 years of age) followed by two further phases. The first phase is compulsory and consists of Primary School (5 years) and Middle School (3 years). The second phase is split into two; High Secondary School, which lasts for 5 years and comes under the jurisdiction of the State and is provided by Lyceum, Technical Schools or Professional Institutes, and Education and Vocational Training, which falls under the jurisdiction of the Regions. Vocational training can be divided into initial vocational training for young people entering work for the first time and continuing vocational training for people who are already working and want to improve their skills, or people excluded from the labour market and who wish to retrain for a new or a better job. These courses, which are mostly free, enable participants to gain the skills and qualifications required by the labour market. Access to university is reserved for students who pass the State exam at the end of their secondary schooling. University programmes are divided into two cycles; three years plus two years of specialisation. Adult learners pay for their education.

In Cyprus education is compulsory from the entry stages of pre-primary, primary, and lower secondary level until the age of 15. Higher secondary education is provided by lyceums, and within these, some technical schools provide vocational education training. Technical schools offer two separate three- year programmes which cover theoretical and practical pathways. Adult education and training is provided by the Ministry of Education and Culture, the Ministry of Labour and Social Insurance, the Ministry of Finance, and private institutions. Adult education refers to formal and informal learning, as well as vocational education and training. Vocational training for adults is widely available for employees, the unemployed, and other vulnerable groups through a mixture of public and private provision. Employees participate in training programmes which address job-specific skills derived from company needs, while the unemployed acquire both horizontal and job-specific skills for improving their employability. However, the percentage of 25 to 64 year-olds participating in education and training is lower than the EU average (Cedefop, 2012). Adult learners are funded by the Ministry of Education and Culture, the Ministry of Labour, and Social Insurance, the Ministry of Finance and private institutions.

Within England there are five stages of education: early years, primary, secondary, Further Education (FE) and Higher Education (HE). Education is compulsory for children between the ages of five and sixteen. The term FE refers to all non-advanced courses taken after the period of compulsory education. In England, further education is often seen as forming one part of a wider learning and skills sector, alongside workplace education, prison education, and other types of non-school, non-university education and training. Responsibility for funding post-16 learning in England is shared between the Department for Education (DfE) and the Department for Business, Innovation and Skills (BIS). The Education Funding Agency (parent organisation is the DfE) is responsible for distributing state funding for 16 – 19 year olds. The Skills Funding Agency (parent organisation is BIS) funds adult FE and skills training. The Higher Education Funding Council for England (HEFCE) is the non-departmental public body of BIS responsible for the distribution of funds to universities and colleges of further and higher education.

Adult learners in England can apply for a range of grants, loans and bursaries to help pay for courses and training, however, the amount available is often dependent on income or other criteria (e.g. disability, dependent children). Tuition fees for HE were first introduced in 1998 as a way of funding tuition to undergraduate and postgraduate students at universities. As a result of the establishment of devolved national administrations for Scotland, Wales and Northern Ireland, different arrangements now exist with regard to tuition fees across the UK. Financial support is available for the cost of university study through a system of grants (dependent on family income) and loans (paid back under a future income-related formula). Universities also provide direct financial support through scholarships which vary from institution to institution both in terms of amount and eligibility criteria.

The Department of Education and Skills (DES) oversees the formal education systems in Ireland at primary, secondary and third level. Compulsory education covers ages four/five to sixteen. Within recent years there has been a significant change in educational provision for adults with new organisational arrangements emerging. These are distinct from the university/information technology sector;

Further education is now provided through the following bodies;

- Education Training Boards (ETBs) which provide full-time adult provision through Post Leaving Courses (PLCs), Vocational Training Opportunities Scheme (unemployed over-21s) and Youth reach courses (under-25s who are out of school or in need of education). Part-time provision is via the Back to Education Initiative (BTEI), Adult Literacy and Community Education courses.
- Solas, the further education and training authority which offers apprenticeships and skills training.
- The Department of Social Protection (DSP) links with PLCs and also oversees the Bridge to Work / Job Bridge Initiative and Community Employment Scheme. As these bodies are new, the areas of responsibility and reporting relationships are still being defined.

All post-compulsory education, particularly at college level, is heavily reliant on being funded by the student; e.g. course costs for PLCs and Third Level incur registration fees (e.g. up to €1.000 for a PLC) and university undergraduate student have to pay a Student Contribution Charge and Student Centre Levy. Means tested grants are available to some students to offset costs.

The Romanian educational system consists of four levels: kindergarten, primary, secondary and higher education. Kindergarten is optional for children aged three to six. Formal, compulsory schooling, also called primary school, begins at age six or seven. This level of education (transitioning to secondary schooling) is obligatory until the tenth grade (age 16). At the post-compulsory level there are 3 options included in the public system funded by the government:

1. Professional schooling at Level two for two years (16 to 18) and four years (15 to 18)
2. Specialized Technical Vocational education for three years (18 to 21)
3. Higher education programmes for four to six years (from 19).

In addition to the state funded system, the National Agency for Adult learners sets the standards for continuing education and formal training. Vocational training and adult education are provided

through public or private institutions. Fees are paid by the learners and entry requires the minimum of a high school degree. The Ministry of Labor provides employability programmes, EU or government funded, for any adult who is unemployed and ex-employees, who are beneficiaries of unemployment benefit for one year after the end of the employment.



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